Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 500 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

An Easy and Inexpensive Way to Lower Cholesterol?

To THE EDITOR: After reading the article by Press and colleagues describing the cholesterol-lowering effects of the nutritional supplement chromium picolinate in the January 1990 issue,[1] I treated ten hypercholesterolemic patients with a regimen of chromium picolinate (200 μg chromium daily, a nutritional dose), niacin (1 to 2 grams per day, a pharmacologic dose), and dietary advice. After four weeks of this therapy, the average response was as follows:

- Total cholesterol levels dropped from 7.78 mmol per liter (301 mg per dl) to 5.92 mmol per liter (229 mg per dl) (24%).
- Low-density lipoprotein (LDL) cholesterol levels dropped from 5.66 mmol per liter (219 mg per dl) to 4.14 mmol per liter (160 mg per dl) (27%).
- Triglyceride levels dropped from 1.78 mmol per liter (158 mg per dl) to 1.02 mmol per liter (90 mg per dl) (43%).
- High-density lipoprotein (HDL) levels were unchanged at 1.32 mmol per liter (51 mg per dl); the ratio of LDL to HDL improved substantially, however.

Obviously, these anecdotal data do not allow us to judge the relative contribution of chromium alone to the success of this regimen; nevertheless, the response was certainly clinically notable and comparable to pharmacologic treatment with prescription medications. One patient was treated initially only with niacin; subsequent treatment with a lower dose of niacin plus chromium yielded a better response.

The treatment with chromium picolinate was convenient (one capsule daily), inexpensive, and was not associated with any discernible side effects. Patient acceptance was excellent.

Asymptomatic, insulin-resistant hyperinsulinemia is common in the Western world and appears to be an independent risk factor for cardiovascular disease.[2,3] By promoting tissue insulin sensitivity, good chromium nutrition may provide an additional protective benefit for many hypercholesterolemic persons.

We need controlled studies to assess the efficacy of chromium picolinate use alone, or as an adjunct to diet and niacin, in the treatment of hypercholesterolemia and hypertriglyceridemia.

JEOFFRY B. GORDON, MD
4747 Mission Blvd, Suite 4
San Diego, CA 92109

REFERENCES

1. Press RI, Geller J, Evans GW: The effect of chromium picolinate on serum cholesterol and apolipoprotein fractions in human subjects. West J Med 1990; 152: 41-45

2. Reaven GM: Role of insulin resistance in human disease. Diabetes 1988; 37:1595-1607

3. Type 2 diabetes or NIDDM: Looking for a better name (Editorial). Lancet 1989; 1:589-591

Primary Biliary Cirrhosis Coexisting With Sarcoidosis—or Possibly Sjögren's Syndrome?

To THE EDITOR: Leff and colleagues recently reported the case of a 40-year-old woman with coexistence of primary biliary cirrhosis and sarcoidosis.[1] It is difficult to determine whether the pulmonary granulomas of this case were due to primary biliary cirrhosis or to coexistent sarcoidosis, however. Pulmonary manifestations in primary biliary cirrhosis can be attributed to the emergence of a granulomatous disorder in the lungs similar to sarcoidosis.[2] The patient had few symptoms or laboratory data that helped make the diagnosis of sarcoidosis. We agree that the case may represent the coexistence of primary biliary cirrhosis and sarcoidosis and, from the rheumatologic point of view, would like to make some comments.

Lymphocytic interstitial pneumonitis, or so-called pseudolymphoma, which is commonly associated with Sjögren's syndrome, may occur in patients with primary biliary cirrhosis, as Leff and co-workers mentioned in their article. Pseudolymphoma is most common in women in their 40s and often manifested as a tumorlike mass (coin lesion) in a chest radiograph. In these patients granulomas are sometimes observed.[3] Did this patient have any immunologic or histologic evidence of Sjögren's syndrome? Even if there were dry eyes and dry mouth, we must be circumspect in diagnosing sicca complex as Sjögren's syndrome because sarcoidosis has been associated with dry eyes and mouth.[4] Minor salivary gland biopsy is used also for diagnosing sarcoidosis, with results showing typical noncaseating granulomas in about half of patients.[4] We are intrigued with the possibility of the coexistence of sarcoidosis and Sjögren's syndrome.[5] An association of thyroiditis, Addison's disease, Sjögren's syndrome, and sarcoidosis—TASS syndrome—has also been reported from California.[6] It could be speculated that the histologic or clinical similarities among primary biliary cirrhosis, sarcoidosis, and Sjögren's syndrome suggest a continuum of disease.

HIDETO AKAMA, MD
Division of Rheumatology
Department of Internal Medicine
Keio University School of Medicine
35 Shinanomachi, Shinjuku-ku
Tokyo 160, Japan

TADASHI YOSHIDA, MD
SHINICHI KAWAI, MD
Division of Rheumatic Disease
Tokyo Metropolitan Ohtsuka Hospital
Tokyo 170, Japan

REFERENCES

1. Leff JA, Ready JB, Repetto C, Goff JS, Schwarz MI: Coexistence of primary biliary cirrhosis and sarcoidosis. West J Med 1990; 153:439-441

2. Spiteri MA, Clarke SW: The nature of latent pulmonary involvement in primary biliary cirrhosis. Sarcoidosis 1989; 6:107-110

3. Crystal RG: Interstitial lung disease, chap 63, *In* Wyngaarden JB, Smith LH Jr (Eds): Cecil Textbook of Medicine, 18th Ed. Philadelphia, Pa, WB Saunders, 1988, pp 421-435

4. Drosos AA, Constantopoulos SH, Psychos D, et al: The forgotten cause of sicca complex—Sarcoidosis. J Rheumatol 1989; 16:1548-1551